UnitedHealthcare Community Plan Heritage Health Overview

Home and Community-Based Services Stakeholders

September 29, 2016

UnitedHealthcare®
Community Plan

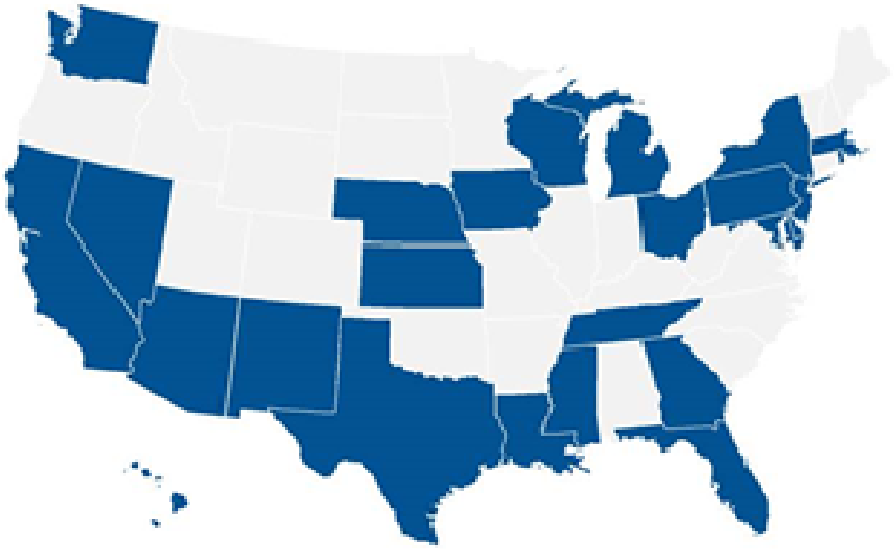
Our United Culture

UnitedHealthcare Community Plan

Our mission is to help people live healthier lives.
Our role is to make health care work for everyone.

Integrity.	Honor commitments Never compromise ethics
Compassion.	Walk in the shoes of people we serve and those with whom we work
Relationships.	Build trust through collaboration
Innovation.	Invent the future, learn from the past
Performance.	Demonstrate excellence in everything we do

Our Experience and Capabilities



We partner with **24 states** plus Washington DC to deliver Medicaid Managed Care services and operate Medicare plans for Medicare & Medicaid eligible individuals in 14 states.

- **We serve all populations in managed care** and specialize in serving members with complex needs. Populations include Katie Becketts, individuals with chronic conditions and consistently homeless members
- Provide **innovative solutions** – bridge the gap to make health care more accessible and more affordable

Nebraska Health Plan Facts

UnitedHealthcare Community Plan

- ✓ UnitedHealthcare has been operational in Nebraska since 1984
  - o Total individuals covered – over 428,870
  - o With more than 380 employees in Nebraska market
  - o Over 66 contractors
- ✓ UnitedHealthcare Community Plan of Nebraska
  - o The Health Plan has been serving Nebraska Medicaid members for over 20 years
- ✓ UnitedHealthcare Community Plan of Nebraska has been accredited by the National Committee for Quality Assurance (NCQA) since Aug. 2005

Social Determinants

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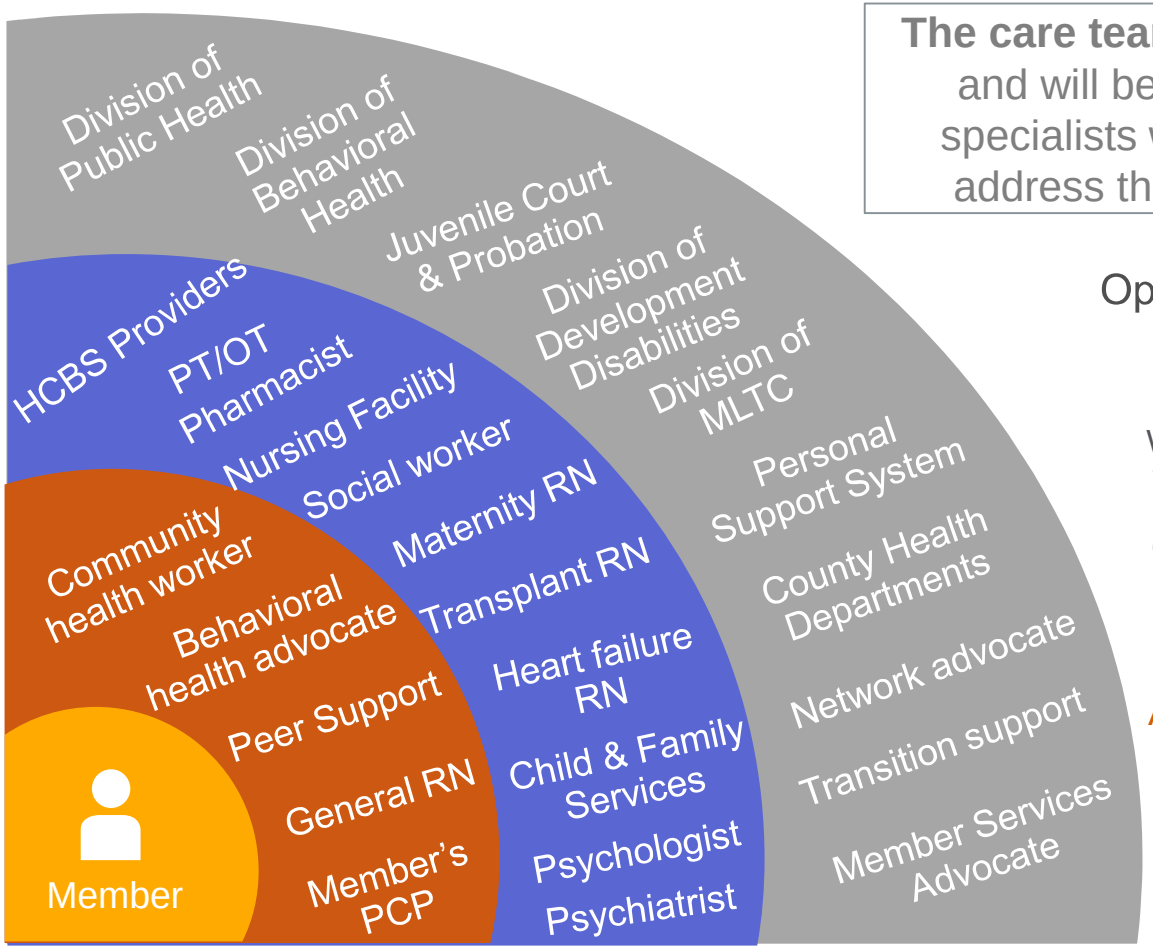
Disease Prevalence	• Disproportionate prevalence of disease states – infant mortality, HIV, high risk pregnancy, physical and mental disabilities, alcohol and substance use • High percentage of adult Medicaid beneficiaries have multiple chronic conditions
Communication Barriers	• Limited education and literacy; poor health care literacy • Non-English speaking household
Transient	• Frequent address changes • Lack of reliable transportation/restricted ability to travel to appointments
Limited Access to Care	• Nationally, the average continuous coverage eligibility is nine months • Lack of providers
Lack of Personal Support Network	• Reliance on community services (shelters, food banks, counseling child care)
Inconsistent Patterns of Care Utilization	• Fragmented care, reduced access to care, lack of routine care and prevention • Emergency Room utilized as primary care substitute
Housing	• Homeless or living in shelters and other community facilities • Need for independent housing options
Food Insecurities	• Food desert in areas of the State • Coordinating food options
Isolation	• Not part of a supportive community • Access to needed resources

Whole Person Care



The care team will report to one leader and will be supported by program specialists who can "flex" to quickly address the needs of the member

Optimal health and well-being

Whole person centered care

Whole person care focuses on how the physical, behavioral and social needs of a person are inter-connected to maintain good health and focus on individuals' personal goals

Aligned to the delivery system

Care focused on supporting the physician to member relationship

Care Management

- Experienced with complex populations
- Comprehensive integrated benefits of physical health, behavioral health and pharmacy
- Single point of contact with UnitedHealthcare's care team
- Care coordination and pharmacy team supports:
  - Transition to home and community-based services
  - Assist monitoring of medications to support appropriate prescribing
  - Avoid conflicting or duplicative prescriptions
  - Assure refills are done on time and convenient for the member

Service Collaboration and Training

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- Assure competence in care coordinators serving I/DD population regarding consumer directed, person-centered assessments and care plans
- Incorporate caregiver participation in the delivery of care and services
- Individuals will be supported through interdisciplinary teams including the member and incorporate the individual's desired outcomes with assessment and person-centered care plans.
- Provide training for care coordinators serving the I/DD population regarding consumer-direction, person-centered practices, communication strategies and family dynamics
  - Care teams ensure a holistic approach in physical, behavioral and long-term services and supports
  - The inter-disciplinary team includes representatives of the agencies providing services

Transition to Managed Care

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- Communications to stakeholders regarding managed care includes the roles, rights and responsibilities of each stakeholder in the system
- Continue collaboration with DHHS service coordinators and advocacy organizations to assure the transition to managed care is smooth, well communicated and person-centered
- Support DHHS and State partners to serve as a consumer advocate to address and resolve member concerns

Our Philosophy for Engagement

- We will engage stakeholders early and often in program development, implementation and evaluation
- We are committed to engaging with DHHS, MCO's and stakeholders in an on-going dialogue to implement person-centered practices.
  - On-going communication eases transition and fosters collaboration
  - Person-centered planning is consistent with CMS guidance/rules
  - The family and their informal supports are the foundation of all services, including benefit design and individual plans of care
  - The health plan has a provider and member advisory committee to provide feedback

Benefits

- Benefits are inclusive to allow for comprehensive, person-centered care and flexible to ensure individuals' independence, community inclusion and quality services/supports
- Program design allows for expanded use and availability of technology
- Benefits are designed with flexibility and breadth to meet the unique needs of individuals with I/DD as they transition from childhood, adolescence, adulthood and end of life
  - Provide a whole-person approach focusing on social supports, lifestyle, behavioral, clinical and LTSS. This holistic focus will improve member experience and comprehensive care

Employment and Housing

- Employment-related services should be part of the individual's assessment and person-centered care plan

- Housing options should consider the least restricted environment maintaining individual safety and member preferences

Contacts-Please call with questions

UnitedHealthcare Community Plan

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